DEPARTMENT OF DEFENSE
TRICARE SUPPORT OFFICE
AURORA, COLORADO 80045-6900

PDR

CHANGE 65
OCHAMPUS 6010.50-M
December 5, 1997

PUBLICATIONS SYSTEM CHANGE TRANSMITTAL FOR AUTOMATED DATA PROCESSING AND REPORTING MANUAL

THE DIRECTOR, OCHAMPUS, HAS AUTHORIZED THE FOLLOWING CHANGE(S) TO OCHAMPUS MANUAL 6010.50-M, REISSUED JULY 1992:

PAGE CHANGE(S): **CHAPTER 2, 5 and 6**

REMOVE AND INSERT PAGE(S): **(See page 2 of this transmittal)**

SUMMARY OF CHANGE(S): THIS CHANGE PROVIDES REQUIREMENTS FOR THE IMPLEMENTATION OF THE MENTAL HEALTH WRAPAROUND DEMONSTRATION. THIS CHANGE IS ISSUED IN CONJUNCTION WITH OPERATIONS MANUAL CHANGE NO. **106.**

EFFECTIVE DATE AND IMPLEMENTATION: UPON DIRECTION OF THE CONTRACTING OFFICER.

Barbara J. Gallegos
for
Sheila H. Sparkman
Director, Program Development and Evaluation

ATTACHMENT(S): 21 PAGE(S)
DISTRIBUTION: 6010.50-M

WHEN PRESCRIBED ACTION HAS BEEN TAKEN, FILE THIS TRANSMITTAL WITH THE BASIC DOCUMENT

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Data Requirements

Chapter 2

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Data Element Definition

Element Name: **Special Processing Code (Continued)**

Code/Value Specifications (Continued)

W	Not-At-Risk payment by at-risk claims processor
X	Partial hospitalization - provider not contracted with or employed by the partial hospitalization program billing for psychotherapy services in a partial hospitalization program
Y	Heart-Lung Transplant
Z	Combined Liver-Kidney Transplant or Kidney only after March 1, 1997
!	Northern Region Coordinated Care
@	Active Duty Cost Share Ambulatory Surgery Taken From Professional Claim.
#	Hospice
$	Capitated arrangements
%	Abused *Family Member*
&	Bone Marrow Transplants - *TSO* approved
*	VA Medical Center Claim
?	Ambulatory Surgery Facility Charge
PO	TRICARE Prime - Point of Service
BD	Bosnia Deductible - 12/8/95
MH	Mental Health Active Duty Cost Share
AD	Active Duty Claims
ST	Specialized Treatment
WR	*Mental Health Wraparound Demonstration*

Algorithm N/A

Notes and Special Instructions:

[1] ***Required if HCSR processing is applicable to special processing conditions. Can report from 1 to 3 codes, left justify and blank fill. Do not duplicate. Each code is two (2) characters. Left justify and blank fill. Refer to Addendum K for hierarchy to apply when more than 1 Special Processing Codes must be reported.***

Data Element Definition

Element Name: **Special Processing Code (Continued)**

Subordinate and/or Group Elements

Subordinate	Group
N/A	Processing Code

Notes and Special Instructions:

[1] ***Required if HCSR processing is applicable to special processing conditions. Can report from 1 to 3 codes, left justify and blank fill. Do not duplicate. Each code is two (2) characters. Left justify and blank fill. Refer to Addendum K for hierarchy to apply when more than 1 Special Processing Codes must be reported.***

Figure 2-F-6 CPT-4 Code Exceptions

Description of Procedures	Level I Codes
The following CPT-4 codes shall not be used when submitting payment records to TSO.	
Anesthesia Codes:	00100 - 01999 (except 01996) 99100 - 99140

NOTE:

FI/Contractors shall report the surgery procedures as appropriate with the provider specialty coded as "anesthesiology" (05) or "anesthetist" (80) as appropriate. A "0" or a "1" must be coded in the Number of Services field. This field must be coded as "1" on all RPM = Blank or H initial submission **payment records**. *FI/Contractors shall request specific information concerning pricing from the providers, however, pricing units are not to be submitted on payment records.*

Figure 2-F-7 Mental Health Procedure Codes

Description of Procedure	Level III Codes
Partial Hospitalization	
Outpatient services provided in a group setting by a Substance Use Disorder Rehabilitation Facility.	90808
Partial Hospitalization, all-inclusive per diem payment for alcohol rehabilitation, 6 hours or more	92891
Partial Hospitalization, all-inclusive per diem payment for alcohol rehabilitation, 3-5 hours (half day program)	92892
Partial Hospitalization, Night Time Care (reimbursement not to exceed amount allowed for half day)	92893
Psychiatric Partial Hospitalization, all inclusive per diem payment of nonsubstance abuse partial hospitalization programs of 6 hours or more	92898
Psychiatric Partial Hospital, all-inclusive per diem payment of nonsubstance abuse programs of 3 - 5 hours, (half-day program)	92899
Wraparound Demonstration	
Psychiatric in home services (psychotherapy provided in the beneficiary's home)	*90892*
Brief, time limited, respite services	*90893*
Therapeutic foster homes (psychotherapy provided in the foster home)	*90894*
Therapeutic group homes (psychotherapy provided in the group home)	*90895*
Crisis stabilization in group homes (psychotherapy provided in a group home, patient unstable)	*90896*
Other residential or nonresidential ancillary mental health services not included in the above codes	*90897*

NOTE:

The only other service that may be cost-shared, in addition to these codes is the one hour of psychotherapy per day for individual or family therapy (not to exceed five per week) performed by authorized mental health professionals not employed by or contracted with the partial hospitalization facility.

Figure 2-F-7 Mental Health Procedure Codes (Continued)

Description of Procedure	Level III Codes

NOTE:

Wraparound Services include nontraditional mental health services that will provide the flexibility needed to assist a child or adolescent to be maintained in the least-restrictive and least-costly setting. This demonstration will be implemented February 1, 1998 and run for two years. Medically necessary institutional care, i.e., provided in a psychiatric hospital, RTC, etc., under this demonstration shall be billed on the appropriate institutional claim form. ***All Mental health services both ancillary and institutional shall be coded by Merit Behavioral Corporation (MBC) with the special processing code for this demonstration.***

Figure 2-F-8 Special *Codes for* the Program for *Persons with Disabilities*

Description of Procedure	Level III Codes

The following special codes shall be used when submitting payment records containing the following Program for *Persons with Disabilities* procedures. This listing does not include all possible codes that should be used for PF*PWD* beneficiaries such as laboratory and radiology. Valid CPT-4 codes shall be used when appropriate.

Vocational or Educational Services	
Visiting Teacher Services	98220
Vocational Training in Sheltered Workshop or Similar Facility	98230
Vocational Training Services for Homebound Patient	98240
Reading Therapy	98250
Other Special Education or Vocational Services	98290

Purchase or Rental of Durable Medical Equipment

See *Figure 2-F-2*

Figure 2-F-9 OCHAMPUS-Assigned Procedural Codes for Reporting Facility Charges when an ONAS is Required

MDC	Category Description	OCHAMPUS Code
61	GYN Laparoscopy	58998
62	Cataract Removal	66998
63	GI Endoscopy	43299
64	Myringotomy or Tympanostomy	69438
65	Arthroscopy	29900
66	Dilation and Curettage	58125
67	Tonsillectomy or Adenoidectomy	42839
68	Cystoscopy	52345
69	Hernia	49595
70	Nose Repair	30525
71	Ligation or Transection of Fallopian Tubes	58625
72	Strabismus Repair	67338
73	Breast Mass or Tumor Excision	19135 (effective 1 Jan 94)
74	Neuroplasty	64730

Note:

For outpatient services provided on or after September 23, 1996, the ONAS requirement is eliminated for all TRICARE/CHAMPUS beneficiaries.

PROCEDURE:

This figure applies only for care provided during period of October 1, 1991 through September 22, 1996. The CHAMPUS claims processors are required to use the above OCHAMPUS codes to report facility-related ambulatory surgery charges on a non-institutional HCSR when an ONAS is required. They will convert the revenue codes (if submitted on a UB-82), or other CPT-4 codes (if submitted on another claim form) to the appropriate OCHAMPUS code from the above list, and report it along with the facility charges on a non-institutional

HCSR. All facility charges are to be summarized and reported under the appropriate code; no itemization is to be reported.

If multiple surgeries are performed during the same episode of care, the claims processors should attempt to report the facility charges for each surgery using the appropriate code from the list above. If this is not possible, all charges should be summarized and reported under the primary surgical procedure code.